



Creative Mentoring®

A Program of Connecting Generations

The information provided in this application will help to match you with a student and will be kept confidential. Please print all information.

First Name _____ MI _____ Last Name _____

Birth Date _____ Last 4 Digits of SS# _____

Street Address _____

City _____ County _____ State _____ Zip Code _____

Previous States in Which You've Lived _____

Home Email _____

Home Phone _____ Cell Phone _____

Gender Male Female

Race African-American Asian Caucasian Hispanic
 Indian Native American Other _____

References

Please list the names, email addresses and DAYTIME PHONE NUMBERS of three persons (non-family members) who have known you for at least three years either personally or professionally.

Reference # 1

Name _____ Years Known _____ Relationship _____

Email Address _____ Phone Number _____

Reference # 2

Name _____ Years Known _____ Relationship _____

Email Address _____ Phone Number _____

Reference # 3

Name _____ Years Known _____ Relationship _____

Email Address _____ Phone Number _____

School Choice Information (For a complete listing, please visit our website www.creativementoring.org)

First School Choice _____ Second School Choice _____

What grade level do you prefer? K-2 3-5 6-8 9-12

Employer Information

Company Name and Occupation _____

Length of Current Employment _____ Year(s) _____ Month(s)

Street Address _____

City _____ County _____ State _____ Zip Code _____

Work Phone _____ May we call you at work? Yes No

Referral

How did you hear about the Creative Mentoring program? _____

About Yourself

Emergency Contact Name _____ Phone _____

Please tell us about yourself: Interests, Family, Volunteer Activities, Etc.

Have you ever mentored or worked with children? (Please tell us about your experiences)

Other Languages Spoken _____

Have you ever been refused participation in any other youth programs? Yes No

If yes, please explain: _____

Have you ever been arrested? Yes No

Have you had any involvement with the police or courts? Yes No

If you answered yes to either of the two questions above, please explain:

As a condition of volunteering, I give permission to conduct a background check on me, which may include a review of sex offender registries, child abuse and criminal history records or other records where required by local, state or federal law for volunteers working with youth.

The references listed may be contacted by phone, email or mail.

Creative Mentoring's records are not available for review by volunteers, children or parents/guardians. All personal information shall be treated in a confidential manner.

Completion of this application does not guarantee acceptance into this program.

Signature _____ Date _____

Please return completed application packet to:

Creative Mentoring
100 W. 10th Street, Suite 1115
Wilmington, DE 19801

Phone: 302.656.2122
Toll Free: 1.800.202.9050
Fax: 302.656.2123
www.creativementoring.org



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Mentor Agreement

As a Creative Mentor, I _____ agree

(Print Name Here)

- To attend a Power of One training session before beginning to mentor.
- To meet with my mentee for 30 minutes to one hour each week, for at least the remainder of the current school year. (I understand that continuing this relationship beyond this school year is encouraged.)
- To be on time for my scheduled mentoring sessions.
- To notify the school or school coordinator if I am unable to attend my weekly mentoring session.
- To engage in the mentoring relationship with an open mind.
- To ask for help and accept assistance from my mentee's teachers, support staff, and school coordinator when necessary.
- To keep discussions with my mentee confidential except where his/her safety and/or welfare may be in jeopardy.
- To notify Creative Mentoring and the school coordinator of any changes in my employment, address, and/or telephone numbers.
- To notify the school coordinator if I wish to change my assigned student or schedule.
- To complete and submit a Creative Mentoring end of year evaluation when due.
- To notify Creative Mentoring and the school coordinator if I no longer wish to mentor.
- To attend a Creative Mentoring training session once every two years to renew my mentor certification.
- **To meet with my mentee only in school or during school-sponsored activities as stated in his/her parents' permission form.**

Signature

Date

NAME: _____ DATE: _____

Volunteer Location _____

HEALTH QUESTIONNAIRE FOR VOLUNTEERS

All school employees are required to have a tuberculosis (TB) skin test. The purpose of this requirement is to safeguard school-aged children from exposure to TB in the school setting. In the same way, this questionnaire is designed to identify volunteers who MAY have been exposed to TB and thus need further screening. A school designee will collect and monitor the Health Questionnaire, which will be stored in the School Nurse's office in a confidential matter.

Please consider the following questions:

1. Have you ever lived with or been in close contact with anyone who had TB disease?
2. Have you ever had a positive HIV test?
3. Have you ever used illegal intravenous drugs?
4. Have you ever been incarcerated?
5. Have you ever been homeless?
6. Do you currently have any of the following symptoms that are unexplained and that have lasted at least three weeks?
 - Cough
 - Fever
 - Night sweats
 - Weight loss
7. Consider the list of countries/continents below:
 - Africa
 - Asia, including China, Vietnam, Korea, Indonesia, Pakistan and Bangladesh
 - Eastern Europe, including Russia and the former Soviet Union, Armenia
 - Haiti
 - Latin America, including Mexico, Guatemala, and South America
 - Pacific Islands, including Philippines

Were you born in one of these countries?

Have you ever stayed/lived in one of these countries for one month or longer?

Have you ever lived or been in close contact with someone who stayed/lived in one of these countries for one month or longer?

Can you answer "yes" to any of the above questions? () YES () NO

If you checked **yes**, you are **required** to have a Mantoux test before your assignment as a volunteer.

Have you ever had a positive skin test for tuberculosis? () YES () NO

If you checked **yes**, you are **required** to provide documentation related to current disease status before your assignment as a volunteer.

These requirements are for the safety of our school and for your personal health. Screening for tuberculosis is recommended by health professionals for any individual who is at risk. Routine screening, using a Mantoux tuberculin skin test, can detect if a person has been exposed to tuberculosis. Such early identification is of great benefit in reducing the effects of the disease.

If you have any questions about your risk of infection, please speak with your healthcare provider or plan to discuss it at your next examination. For additional information, you can contact the Delaware Division of Public Health TB Elimination Program at (302) 739-6620.

Approved by Division of Public Health, May 1999.



DELAWARE CHILD PROTECTION REGISTRY REQUEST FORM



Fax or Mail Request to:

DSCYF, OCCL
Criminal History Unit
1825 Faulkland Road
Wilmington, DE 19805

Phone: 302-892-5800 Fax: 302-633-5191

When requesting Child Protection Registry checks:

- **Allow 15 working days for results to be processed**
- **Do not use a cover sheet**
- **Do not send duplicate requests**
- **Form must be submitted to DSCYF within 90 days of signature date in order to be processed**

PART I. APPLICANT INFORMATION *(PLEASE PRINT CLEARLY)*

Name: _____
Last First Middle

Other Name(s) used: _____ DE Drivers License # _____

Social Security # _____ - _____ - _____ Date of Birth: _____ - _____ - _____ Sex: _____ Race: _____
mm / dd / yyyy

Address: _____
(Street) (City) (State) (Zip)

Have you ever been involved in a substantiated case of child abuse or neglect? [] Yes [] No

If Yes, explain: _____

I hereby authorize The Delaware Department of Services for Children, Youth and Their Families to provide the below named agency/organization with all substantiated cases of child abuse or neglect concerning me contained in the Child Protection Registry. I further release the Delaware Department of Services for Children, Youth and Their Families, its officers and employees from any and all claims arising out of or in any way connected to the release or dissemination of any information concerning me.

Signature: _____ Date: _____

Parent / Guardian Signature (If applicant is under the age of 18) _____

PART II. AGENCY/ORGANIZATION INFORMATION - *(MUST BE COMPLETED IN ORDER TO PROCESS)*

<p>Please check only one:</p> <p><input type="checkbox"/> EDUCATION <input type="checkbox"/> HEALTH CARE FACILITY <input type="checkbox"/> CHILD CARE <input checked="" type="checkbox"/> OTHER _____</p>

Agency Identification Number (if applicable): N/A

Requesting Agency Name: Connecting Generations

Address: 100 West 10th Street, Suite 1115, Wilmington, DE 19801

Phone: (302)656-2122 Fax: (302)656-2123 Contact Person: Jennifer Marek

DSCYF USE ONLY:

The individual listed above (___ is listed) (___ is NOT listed) on the Delaware Child Protection Registry.

Date: _____ DSCYF Criminal History Unit _____